Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

PINE CREEK MEDICAL CENTER
9032 HARRY HINES BLVD
DALLAS TX 75235-1720

Respondent Name
AMERICAN MOTORISTS INSURANCE COMPANY

Carrier's Austin Representative Box
Box Number 21

MFDR Tracking Number
M4-12-0656-01

MFDR Date Received
October 31, 2011

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Carrier failed to reimburse claim in accordance with Medicare bilateral procedure guidelines which states that bilateral procedures are to be paid @ 150% of the fee schedule."

Amount in Dispute: $2,055.06

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The Carrier's position is that the reimbursement of $1,027.53 for each of the four dates of service is correct and no further reimbursement is due. CMS Claim Processing Guidelines specifically provides in section 40.7 that if field 22 contains an indicator of '0,' '2,' or '3,' the payment adjustment rules for bilateral surgeries do not apply. The procedure code at issue contains an indicator of '0' for which the bilateral procedure rule does not apply."

Response Submitted by: Thornton, Biechlin, Segrato, Reynolds & Guerra, LC, 912 S. Capital of Texas Highway, Suite 300, Austin Texas 78746-5242

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
June 22, 2011 to July 26, 2011	Outpatient Hospital Services	$2,055.06	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.403, titled *Hospital Facility Fee Guideline – Outpatient*, sets out the reimbursement guidelines for facility services provided in an outpatient acute care hospital.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:

- W1 – Workers Compensation State Fee Schedule Adjustment
- W1 – Workers' compensation jurisdictional fee schedule adjustment. Note: If adjustment is at the Claim Level, the payer must send and the provider should refer to the 835 Class of Contract Code Identification Segment (Loop 2100 Other Claim Related Information
- W4 – O - Denial after reconsideration/based on further review, no payment is warranted.
- 595-001 – THE REIMBURSEMENT AMOUNT IS BASED ON THE MEDICARE REIMBURSEMENT PLUS THE PERCENTAGE INCREASE SPECIFIED BY THE STATE.
- 900-001 – O-DENIAL AFTER RECONSIDERATION BASED ON FURTHER REVIEW, NO PAYMENT IS WARRANTED.

Issues

1. Are the disputed services subject to a contractual agreement between the parties to this dispute?
2. What is the applicable rule for determining reimbursement for the disputed services?
3. What is the recommended payment amount for the services in dispute?
4. Is the requestor entitled to reimbursement?

Findings

1. Review of the submitted documentation finds no information to support that the disputed services are subject to a contractual agreement between the parties to this dispute.
2. This dispute relates to facility services performed in an outpatient hospital setting with reimbursement subject to the provisions of 28 Texas Administrative Code §134.403, which requires that the reimbursement calculation used for establishing the maximum allowable reimbursement (MAR) shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Outpatient Prospective Payment System (OPPS) reimbursement formula and factors as published annually in the Federal Register with the application of minimal modifications as set forth in the rule. Per §134.403(f)(1), the sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 200 percent, unless a facility or surgical implant provider requests separate reimbursement of implantables. Review of the submitted documentation finds that separate reimbursement for implantables was not requested.
3. Under the Medicare Outpatient Prospective Payment System (OPPS), each billed service is assigned an Ambulatory Payment Classification (APC) based on the procedure code used, the supporting documentation and the other services that appear on the bill. A payment rate is established for each APC. Depending on the services provided, hospitals may be paid for more than one APC per encounter. Payment for ancillary and supportive items and services, including services that are billed without procedure codes, is packaged into payment for the primary service. A full list of APCs is published annually in the OPPS final rules which are publicly available through the Centers for Medicare and Medicaid Services (CMS) website. Reimbursement for the disputed services is calculated as follows:

   Date of service June 22, 2011

   - Procedure code Q9966 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into payment for other services, including outliers.
   - Procedure code 77003 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into payment for other services, including outliers.
   - Procedure code 64517 has a status indicator of T, which denotes a significant procedure subject to multiple procedure discounting. The highest paying status T APC is paid at 100%; all others are paid at 50%. This procedure is paid at 100%. This service is classified under APC 0207, which, per OPPS Addendum A, has a payment rate of $522.67. This amount multiplied by 60% yields an unadjusted labor-related amount of $313.60. This amount multiplied by the annual wage index for this facility of 0.9716 yields an adjusted labor-related amount of $304.69. The non-labor related portion is 40% of the APC rate or $209.07. The sum of the labor and non-labor related amounts is $513.76. The cost of this service does not exceed the annual fixed-dollar threshold of $2,025. The outlier payment amount is $0. The provider appended modifier 50 to the procedure code, indicating a bilateral procedure. The bilateral surgery indicator for procedure code 64517 is 0. Per Medicare policy, the 150 percent payment adjustment for bilateral procedures does not apply to procedures with a bilateral surgery indicator of 0. The bilateral adjustment is inappropriate for codes in this category because of physiology or anatomy, or because the code descriptor specifically states that it is a unilateral procedure. The total APC payment for this service is $513.76. This amount multiplied by 200% yields a MAR of $1,027.52.
   - Procedure code Q9966 has a status indicator of N, which denotes packaged items and services with no

separate APC payment; payment is packaged into payment for other services, including outliers.

Date of service June 28, 2011

- Procedure code 77003 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into payment for other services, including outliers.
- Procedure code 64517 has a status indicator of T, which denotes a significant procedure subject to multiple procedure discounting. The highest paying status T APC is paid at 100%; all others are paid at 50%. This procedure is paid at 100%. This service is classified under APC 0207, which, per OPPS Addendum A, has a payment rate of $522.67. This amount multiplied by 60% yields an unadjusted labor-related amount of $313.60. This amount multiplied by the annual wage index for this facility of 0.9716 yields an adjusted labor-related amount of $304.69. The non-labor related portion is 40% of the APC rate or $209.07. The sum of the labor and non-labor related amounts is $513.76. The cost of this service does not exceed the annual fixed-dollar threshold of $2,025. The outlier payment amount is $0. The provider appended modifier 50 to the procedure code, indicating a bilateral procedure. The bilateral surgery indicator for procedure code 64517 is 0. Per Medicare policy, the 150 percent payment adjustment for bilateral procedures does not apply to procedures with a bilateral surgery indicator of 0. The bilateral adjustment is inappropriate for codes in this category because of physiology or anatomy, or because the code descriptor specifically states that it is a unilateral procedure. The total APC payment for this service is $513.76. This amount multiplied by 200% yields a MAR of $1,027.52.
- Procedure code Q9966 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into payment for other services, including outliers.

Date of service July 5, 2011

- Procedure code 77003 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into payment for other services, including outliers.
- Procedure code 64517 has a status indicator of T, which denotes a significant procedure subject to multiple procedure discounting. The highest paying status T APC is paid at 100%; all others are paid at 50%. This procedure is paid at 100%. This service is classified under APC 0207, which, per OPPS Addendum A, has a payment rate of $522.67. This amount multiplied by 60% yields an unadjusted labor-related amount of $313.60. This amount multiplied by the annual wage index for this facility of 0.9716 yields an adjusted labor-related amount of $304.69. The non-labor related portion is 40% of the APC rate or $209.07. The sum of the labor and non-labor related amounts is $513.76. The cost of this service does not exceed the annual fixed-dollar threshold of $2,025. The outlier payment amount is $0. The provider appended modifier 50 to the procedure code, indicating a bilateral procedure. The bilateral surgery indicator for procedure code 64517 is 0. Per Medicare policy, the 150 percent payment adjustment for bilateral procedures does not apply to procedures with a bilateral surgery indicator of 0. The bilateral adjustment is inappropriate for codes in this category because of physiology or anatomy, or because the code descriptor specifically states that it is a unilateral procedure. The total APC payment for this service is $513.76. This amount multiplied by 200% yields a MAR of $1,027.52.
- Procedure code Q9966 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into payment for other services, including outliers.

Date of service July 26, 2011

- Procedure code 77003 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into payment for other services, including outliers.
- Procedure code 64517 has a status indicator of T, which denotes a significant procedure subject to multiple procedure discounting. The highest paying status T APC is paid at 100%; all others are paid at 50%. This procedure is paid at 100%. This service is classified under APC 0207, which, per OPPS Addendum A, has a payment rate of $522.67. This amount multiplied by 60% yields an unadjusted labor-related amount of $313.60. This amount multiplied by the annual wage index for this facility of 0.9716 yields an adjusted labor-related amount of $304.69. The non-labor related portion is 40% of the APC rate or $209.07. The sum of the labor and non-labor related amounts is $513.76. The cost of this service does not exceed the annual fixed-dollar threshold of $2,025. The outlier payment amount is $0. The provider appended modifier 50 to the procedure code, indicating a bilateral procedure. The bilateral surgery indicator for procedure code 64517 is 0. Per Medicare policy, the 150 percent payment adjustment for bilateral procedures does not apply to procedures with a bilateral surgery indicator of 0. The bilateral adjustment is inappropriate for codes in this category because of physiology or anatomy, or because the code descriptor specifically states that it is a unilateral procedure. The total APC payment for this service is $513.76. This amount multiplied by 200% yields a MAR of $1,027.52.

- Procedure code Q9966 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into payment for other services, including outliers.

4. The total allowable reimbursement for the services in dispute is $4,110.08. This amount less the amount previously paid by the insurance carrier of $4,110.12 leaves an amount due to the requestor of $0.00. No additional reimbursement can be recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

	Grayson Richardson	October 12, 2012
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.